"It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something."

-Franklin D. Roosevelt

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OIDP
Office of Injury and Disability Programs
Kansas Department of Health and Environment

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Kansas State Plan *for* Promoting The Health of People with Disabilities

HEALTHY KANSANS 2010

...Encourage Change...Improve The Health of All Kansans

KANSAS
OFFICE OF THE GOVERNOR

Kathleen Sebelius, Governor

www.governor.ks.gov

Dear Fellow Kansans:

My administration is committed to improving the health of all Kansans. With the development of the Healthy Kansans 2010 State Plan for Promoting the Health of People with Disabilities, we build on a comprehensive, nationwide health promotion and disease prevention agenda that's focused on increasing the quality of life and eliminating health disparities within our state.

We have an obligation to help every Kansan reach his or her full potential. Our state's constitution specifically calls on us to help our fellow citizens with special needs. Kansans with disabilities are living productive and independent lives and the Kansas Disability and Health Program is an important part of expanding opportunities for more of our citizens to reach their full potential.

I challenge all Kansans to help turn this plan into action. Together we can successfully promote the health of people with disabilities and make Kansas an even better place to call home.

Sincerely yours,

Kathleen Sebelius

Kathleen Sebelius
Governor of the State of Kansas

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Acknowledgements

A special thanks is extended to all partners and people with disabilities who share the mission to eliminate secondary conditions and promote the health of people with disabilities. Through their hard work and commitment to make change for the better, this plan was made possible.

- Kansans with Disabilities
- Research and Training Center on Independent Living at Kansas University
- Kansas Association Centers for Independent Living
- Kansas Coalition Against Sexual and Domestic Violence
- Statewide Independent Living Council of Kansas Department of Health and Environment
- Brain Injury Association
- Kansas Social and Rehabilitation Services
- Washburn University
- Kansas Department of Health and Environment:
- Breast and Cervical Cancer Prevention
- Bioterrorism Program
- Physical Activity and Nutrition Program
- Tobacco Prevention Program
- Sexual Assault Prevention Program
- Fire Burn Prevention Program
- Injury Prevention Program
- Arthritis Program
- Cardiovascular and Health Program
- Diabetes Program

Disability Awareness

Change happens through language. Professional communicators, educators, the media and human service providers are in a unique position to shape the public image of people with disabilities.

The words we choose can provide a negative or positive image. The following phrases are provided by the Research and Training Center on Independent Living, University of Kansas.

SAY	DON'T SAY
Nondisabled	Able-bodied
Person with a brain injury	Brain damaged
Psychiatric disability	Insane
Person with a spinal cord injury	Paralyzed
Person with mental retardation	Retarded
Children with disabilities	Special children
Stroke survivor	Stroke victim
Uses a wheelchair	Wheelchair-bound
Person with a disability	Crippled
Person of short stature	Dwarf or Midget

"*A hero is an ordinary individual* who finds the strength to persevere *and* endure in spite of overwhelming obstacles."

– Christopher Reeve

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Forward

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Dear Fellow Kansans:

I'm pleased to introduce the Kansas State Plan for Promoting the Health of People with Disabilities. The plan reflects the commitment and dedication of more than 30 organizations, programs and associations who came together to develop effective strategies for promoting a healthy lifestyle among people with disabilities. It describes the health disparities that exist for people with disabilities and presents goals and strategies to improve the health of people with disabilities.

The plan is designed to provide a common framework of priorities for action to drive collaboration in assembling available resources and uniting related programs to elevate disability health issues to a higher profile, thereby, producing a greater impact in the community at large.

The Kansas State Plan for Promoting the Health of People with Disabilities was strongly influenced by another state health planning process conducted throughout 2005: "Healthy Kansans 2010 - Learning from the Past, Preparing for the Future". The Healthy Kansans 2010 process involved a group of Kansans representing multiple disciplines and organizations that came together to identify and adopt health priorities to improve the health of all Kansans. Through a series of working sessions, a steering committee of more than 30 appointed representatives reviewed the Kansas data to compare Kansas' health status with that of the nation. Three cross-cutting priorities were identified as offering the greatest promise for improving Kansas' health status as measured by the 10 Leading Health Indicators highlighted in "Healthy People 2010". That report outlines the national health objectives for the nation, developed by the US Department of Health and Human Services.

The priority areas selected through the Healthy Kansans 2010 process include: early disease prevention, risk identification and intervention for women, children and adolescents; system interventions to address the social determinants of health; and the elimination of health and disease disparities among population sub-groups.

More than 200 stakeholders and content experts identified issues and implementation steps to operationalize a response to the three priority areas. Recommendations were selected based on their ability to motivate action, availability of data to measure their progress and relevance as broad health issues. The recommendations illuminated individual behaviors, physical and social/environmental factors and important health system issues that greatly affect the health of individuals and communities.

After the priorities and recommendations were established, follow-through groups (such as the Disability and Health Advisory Group) accepted responsibility for developing action plans that can have a profound effect on increasing quality of life and years of healthy life for all Kansans. The agency will track and communicate progress towards improved health status of all Kansans through the end of the decade. The Executive Summary of Healthy Kansans 2010 is included in the resource section of this document. The full document is available at www.healthykansans2010.org.

I hope that the goals and strategies put forward in this plan, along with Healthy Kansans 2010, will secure a healthy and prosperous future for all Kansans.

Be well,

Roderick L. Bremby

Secretary

"*I believe* that there is **unlimited opportunity** for the health of Kansas to improve. *I also believe* that the only place for Kansas as we measure the health status of our nation is **first.**"

– Howard Rodenberg, MD, MPH
Director, KDHE Division of Health and State Health Officer
Address to the Kansas Health Policy Authority, January 2006

the impact

The *impact* of Disability in Kansas

A goal of Healthy People 2010 is to promote the health of people with disabilities and eliminate disparities between people with and without disabilities in the U.S. population (Healthy People 2010, 2002). To date, no clear-cut definition exists for the term "disability". As shown by Lollar (2002) disability can be referred to as (a) diagnosis (e.g., birth defects), (b) activity limitations (e.g. mobility disability), (c) environmental barriers (e.g., lack of ramps), or (d) societal participation (e.g., employment).

In 2002, it was estimated that more than 50 million Americans have an activity limitation/disability associated with long-term physical, sensory, or cognitive conditions (CDC, 2002). These estimates demonstrate that much effort is needed to maintain and improve the quality of lives of those affected and to eliminate the disparities that exist between Americans with and without disabilities.

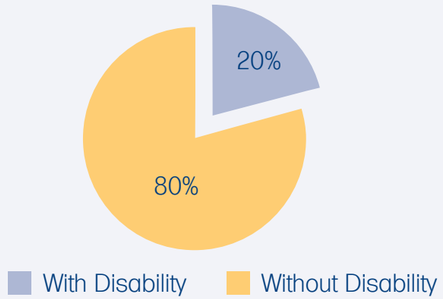
Disability in Kansas

Available data from Kansas Behavioral Risk Factor Surveillance System (BRFSS) highlight disparities among adults living with a disability in Kansas with respect to both the prevalence of disability as well as health status, behaviors, and other health indicators among persons with a disability. Many of these health indicators are related to the ten leading Health Indicators of Healthy People 2010.

Descriptive Epidemiology. Data from the 2005 Kansas BRFSS estimated that there were 393,515 adult Kansans (19.7%) living with a disability (defined as those who reported an activity limitation due to physical, mental, or emotional problems or who reported a health

problem that requires them to use special equipment such as a cane, a wheelchair, a special bed, or a special telephone). (Figure 1)

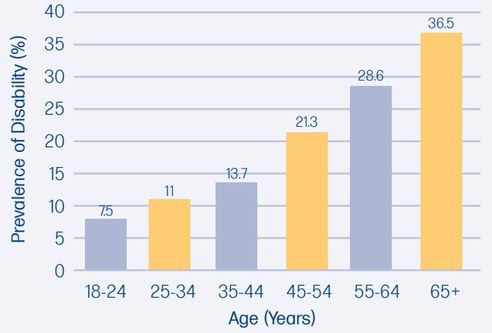
(Figure 1)
DISABILITY STATUS IN KANSAS, BRFSS 2005



Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

The prevalence of disability was similar among females and males (20.2% [95% CI: 19.1% - 21.4%] vs. 19.1% [95% CI: 17.5% - 20.7%], respectively). The prevalence of disability generally increased with age as shown in figure 2.

(Figure 2)
PREVALENCE OF DISABILITY BY AGE, KANSAS BRFSS 2005



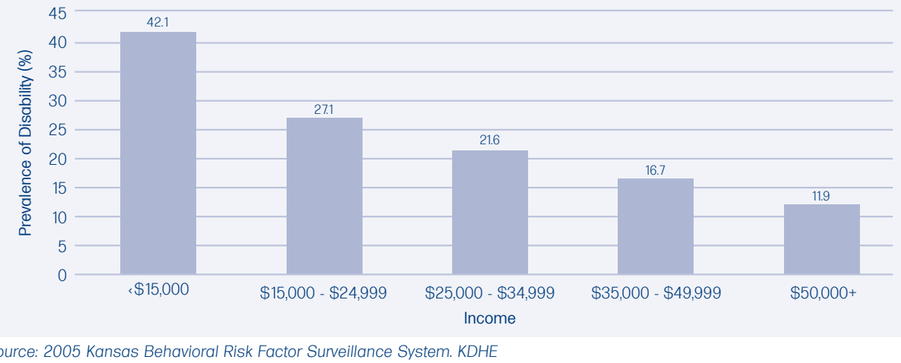
Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

The prevalence of disability varies by ethnicity. The prevalence of disability is higher among non-Hispanics than among Hispanics (20.3% [95% CI: 19.3% - 21.3%] vs. 10.9% [6.3% - 15.4%], respectively). The higher prevalence among non-Hispanics as compared to Hispanics was seen even after adjusting for age.

The prevalence of disability appears to be associated with decreasing levels of socioeconomic status. The prevalence of disability increased with both decreasing levels of household income and with educational

attainment. The prevalence of disability is higher among those with household income of less than $15,000 as compared to those with household income of $50,000 and above (42.1% [95% CI: 36.6%-47.5%] vs. 11.9% [95% CI: 10.6%-13.2%], respectively. (Figure 3) Among adults with less than high school education, the prevalence of disability was estimated at 27.7% (95% CI: 22.9% - 32.5%) compared to 14.4% (95% CI: 13.1% - 15.8%) among adults with college degree.

(Figure 3) PREVALENCE OF DISABILITY BY INCOME LEVEL, KANSAS BRFSS 2005



Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

The prevalence of disability does not appear to vary by population density as shown below.

PREVALENCE OF DISABILITY BY POPULATION DENSITY, KANSAS BRFSS 2005

	Frontier[a]	Rural[b]	Densely-settled Rural[c]	Semi-urban[d]	Urban[e]
Disability (95% CI)	19.2% (12.9%-25.4%)	22.4% (19.4%-25.4%)	21.8 % (19.3%-24.3%)	20.5% (18.4%-22.7%)	17.9% (16.6%-19.3%)

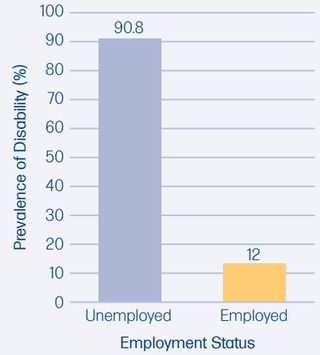
[a] Frontier: Area with less than 6 persons per square mile [b] Rural: Area with 6 to less than 20 persons per square mile
[c] Densely settled Rural: Area with 20 to less than 40 persons per square mile [d] Semi-urban: Area with 40 to less than 150 persons per square mile [e] Urban: Area with 150 + persons per square mile

"Most of the important things in the world have been accomplished by people who have kept on trying when there seemed to be no hope at all."

-Dale Carnegie

The majority of adult Kansans who are unable to work have a disability (90.8% (95% CI: 86.9% - 94.6%) as compared to adults who are either employed for wages or self-employed (12.0% (95% CI: 10.9% - 13.0%). *(Figure 4)* More than one in four adults who reported being out of work reported a disability (29.3% (95% CI: 22.3%-36.4%). The prevalence of disability was highest among adults who were either widowed (42.8 (95% CI: 39.7%-45.9%) or divorced / separated (29.5% (95% CI: 26.6%-32.2%). The prevalence of disability was lowest among adults who were never married or who were married / member of an unmarried couple (14.7% [95% CI: 11.6%-17.8%] and 17.2% [95% CI: 16.15%-18.3%], respectively). ■

(Figure 4)
PREVALENCE OF ADULTS LIVING WITH OR WITHOUT DISABILITY BY EMPLOYMENT STATUS, KANSAS BRFSS 2005



Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

health

health indicators

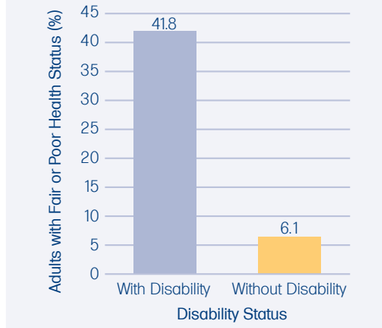
Data from the BRFSS also highlight disparities between persons living with and without a disability. As indicated previously, in the 2005 BRFSS, disability was defined as having activity limitation due to physical, mental, or emotional problems or a health problem that requires the use of special equipment such as a cane, a wheelchair, a special bed, or a special telephone.

Health Status

Self-rated Health: In 2005, the percentage of adult Kansans with a disability who perceive their health status as either fair or poor was six times higher than adults without disability: Prevalence of 41.8% [95% CI: 39.3%-44.4%] among those with disability vs. 6.1% [95% CI: 5.4%-6.8%] among those without disability. *(Figure 5)*

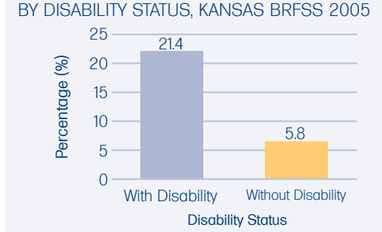
Mental Health: The percentage of adult Kansans with disability who reported that their mental health as not good for 14 or more days in the past 30 days was three times higher than adults without disability:

(Figure 5)
PREVALENCE OF ADULT KANSANS WITH FAIR OR POOR HEALTH STATUS BY DISABILITY STATUS, KANSAS BRFSS 2005



Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

(Figure 6)
PREVALENCE OF ADULT KANSANS REPORTING POOR STATE OF MENTAL HEALTH* BY DISABILITY STATUS, KANSAS BRFSS 2005



** Percentage of adults who reported their mental health was not good on 14 or more days in the past 30 days*
Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

Prevalence of 21.4% (95% CI: 18.9%-23.8%) among those with disability vs. 5.8% (95% CI: 5.1%-6.4%) among those without disability. *(Figure 6)*

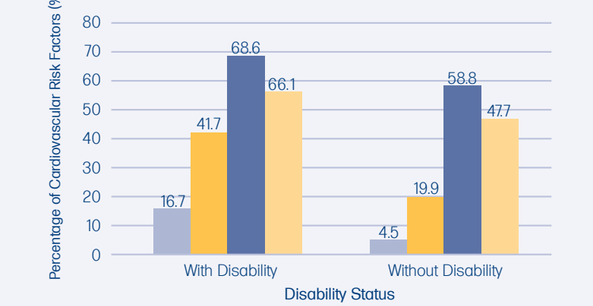
Cardiovascular Risk Factors Among Persons Living With and Without Disability

Data from the BRFSS suggest that persons living with a disability are at increased risk for cardiovascular disease as indicated by the higher prevalence of most of the factors for cardiovascular disease.

Diabetes: The prevalence of diabetes was almost three times higher among those with disability 16.7% (95% CI: 14.8%-18.6%) compared to those without disability 4.5% (95% CI: 4.0%-5.1%).

High Cholesterol Level: The prevalence of high cholesterol level (among those ever tested) was higher among adults with disability 44.9% (95% CI: 42.1%-47.7%) compared to adults without disability 30.2% (95% CI: 28.7%-31.6%). *(Figure 7)*

(Figure 7)
CARDIOVASCULAR RISK FACTORS AMONG ADULTS WITH AND WITHOUT DISABILITY. KANSAS BRFSS 2005



Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

Hypertension: Among adults with disability, the prevalence of diagnosed hypertension was significantly higher 41.7% (95% CI: 39.1%-44.3%) when compared to adults without disability 19.9% (95% CI: 18.8%-20.9%) *(Figure 7)*

Obesity: Based on self-reported height and weight, adult Kansans with a disability reported a significantly higher prevalence of overweight or obesity (defined as body mass index [BMI] › 25) at 68.8% (95% CI: 66.2%-71.4%) compared to adults without disability 58.8% (95% CI: 57.3%-60.4%).

Among adults with a disability, the prevalence of obesity (defined as BMI ≥ 30) was significantly higher (33.8% [95% CI: 31.3%-36.3%]) when compared to adults without disability (21.5% [95% CI: 20.2%-22.7%]). *(Figure 7)*

Inadequate Physical Activity: The prevalence of not participating in the recommended level of physical activity (defined as moderate activities for 30 minutes 5 or more days per week or vigorous activity for 20 minutes 3 or more days per week) is significantly higher among adults with disability 66.1% (95% CI: 63.4%-68.8%) compared to adults without disability 47.7% (95% CI: 46.1%-49.2%). *(Figure 7)*

Smoking Status: The prevalence of current smoking among adults with disability is similar to those without disability (19.2% [95% CI: 17.1%-21.4%) and those without disability (17.4% [95% CI: 16.1%-18.6%]).

Fruits and Vegetables Consumption: A higher percentage of adults with disability reported inadequate consumption of fruits and vegetables (less than five times a day) as compared to those living without disability (76.5% [95% CI: 74.2%-78.7%] vs. 81.0% [95% CI: 79.9%-82.1%], respectively).

Alcohol Consumption

Some disparity is noticed when adult Kansans with and without disability are compared in terms of their alcohol consumption. The prevalence of heavy alcohol consumption (defined as an average of more than two drinks per day among males and more than one drink per day among females during the past 30 days) is lower for adults with disability as compared to those without disability (1.9% [95% CI: 1.1%-2.7%] and 3.4% [95% CI: 2.8%-4.0%], respectively).

Seat Belt Usage

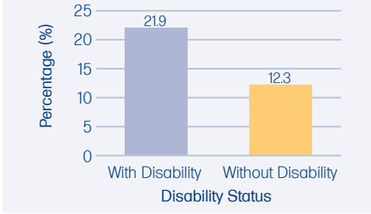
When asked about seatbelt usage, the prevalence of not always wearing a seatbelt while driving does not differ among adults with and without disabilities (25.9% [95% CI: 22.6%-29.2%] vs. 26.8% [95% CI: 24.8%-28.7%], respectively).

Use of Preventive Services

Mammogram: Data from the 2004 BRFSS shows slight disparity when adult females, 40 years and above, who have not had a mammogram within the preceding two years are compared among women with and without disability status. Adult females living with a disability (27.9% [95% CI: 24.9%-30.9%]) have a higher prevalence for not having a mammogram test compared to adult females living without a disability (22.4% [95% CI: 20.6%-24.2%]).

Pap Smear: There also appear to be a significant disparity among women who have not had a pap smear within the preceding three years. Women living with a disability have a higher prevalence of not having a pap smear as compared to women living without a disability (21.9% [95% CI: 18.3%-25.5%] vs. 12.3% [95% CI: 10.9%-13.7%] respectively) *(Figure 8)*

(Figure 8)
PERCENTAGE OF ADULT FEMALE KANSANS WHO HAVE NOT HAD A PAP SMEAR* BY DISABILITY STATUS, KANSAS BRFSS 2004

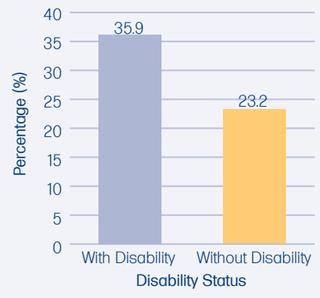


*Female respondents who reported they have not had a pap smear within the preceding three years
Source: 2004 Kansas Behavioral Risk Factor Surveillance System. KDHE*

Health Care Access

Oral Health: Data from the 2004 Kansas BRFSS suggest that adults with a disability are less likely to receive dental care than adults without a disability. Higher prevalence of lack of a recent dental visit (defined as having not visited a dentist, dental hygienist or dental clinic within the past year) is seen among adults living with disability (35.9% [95% CI: 33.4%-38.4%] compared to adults living without disability at 23.2% [95% CI: 22.0%-24.4%]). *(Figure 9)*

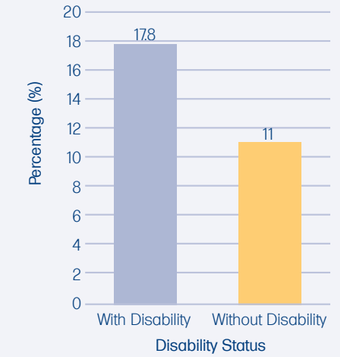
(Figure 9)
PREVALENCE OF ADULT KANSANS WITH LACK OF RECENT DENTAL VISIT BY DISABILITY STATUS, KANSAS BRFSS 2004



Source: 2004 Kansas Behavioral Risk Factor Surveillance System. KDHE

Health Care Coverage and Personal Health Care Provider: Data from 2005 showed no significant difference between adults, ages 18-64 years, living with and without disability who lack health care coverage (18.2% [95% CI: 14.9%-21.5%] vs. 15.1% [95% CI: 13.7%-16.5%]). Higher percentage of adults living with disability reported not having a personal doctor or health care provider as compared to adults living without disability (17.8% [95% CI: 16.4%-19.1%] vs. 11.0% [95% CI: 8.7%-13.2%] respectively). *(Figure 10)*

(Figure 10)
PERCENTAGE OF ADULT KANSANS WITHOUT A PERSONAL DOCTOR OR HEALTH CARE BY DISABILITY STATUS, KANSAS BRFSS 2005



Source: 2005 Kansas Behavioral Risk Factor Surveillance System. KDHE

the program

History and current program activities

Kansas has built collaborative relationships with state partners to establish and maintain the Disability and Health Program (DHP) and achieve significant growth in the state's capacity for examining disability and health issues. Evidence includes the routine inclusion of disability and health issues and data in agency documents, the Kansas Health Indicators Document, and the state-planning processes. The Kansas Disability Caucus, participation by people with disabilities on the Disability and Health Steering Committee, and expanded partnerships to conduct pilot health promotion projects working with the people with disabilities and demonstrating the State's commitment to the special health needs of these Kansans.

The Disability and Health Steering Committee (DHSC) conducted a strategic planning process that resulted in the Kansas Strategic Plan for Disability and Health published in 2000. The plan focused on five priority areas: 1) access, 2) abuse/violence, 3) mental health, 4) physical activity, and 5) data. Through funding from the Centers for Disease Control, the DHSC has updated the state plan and streamlined the focus to include 1) access to health care, 2) abuse/violence, and 3) physical activity/obesity. Mental health was considered by the committee to be a part of every aspect of life, thus improvements in mental health can be expected by addressing the focus area.

In 1999, KDHE's Disability and Health program surveyed both persons with disabilities and parents of children and disabilities on the risk factor

and protective services that affect their health. Respondents voiced their strong support for abuse and violence prevention efforts. Discussions from the focus groups noted that people with disabilities are often at greatest risk of abuse or violence from people who are closest to them and who provide needed support. This project led to a collaborative effort between the Kansas Coalition Against Sexual and Domestic Violence (KCSDV), Kansas Association of Centers for Independent Living (KACIL), Kansas Department of Health and Environment (KDHE), Joint Center of Violence and Victim Studies (JCVVS) at Washburn University and community advocacy agencies resulting in a grant award from the Department of Justice in October 2002. This program provides technical assistance, training, education and awareness to Kansas advocacy programs on violence against women with disabilities. The project complements existing efforts of community-based initiatives through inter-agency training and support to enhance service delivery to women with disabilities experiencing domestic violence or sexual assault by:

1) Offering technical assistance and support. As a result, disability advocates have a greater understanding of abuse and violence, and domestic violence and sexual assault advocates have a greater understanding of disability.

2) Providing technical assistance/support to independent living centers, domestic violence and sexual assault programs, Adult and Child Protective Services, health care, criminal justice and Area Agencies on Aging. This process is aimed at creating a coordinated community response to violence against women with disabilities through the development of cooperative agreements for inter-agency response.

3) Providing legal expertise to facilitate systems change by reviewing rules / regulations / policies / procedures to identify how they create barriers to women with disabilities.

4) Developing posters and brochures to increase awareness.

5) Reproducing existing materials in alternative formats.

Due to the Statewide success of the program, funding for this program was renewed in October 2006.

Preparedness Planning: A strong partnership between KDHE, the Hospital Preparedness Program, and the University of Kansas, Research and Training Center on Independent Living (RTC/IL at the University of Kansas) has been developed to address issues for preparedness of people with disabilities. The Kansas Hospital Preparedness Program and the RTC/IL at the University of Kansas have partnered to enhance planning and preparedness among hospitals, public health and first responders as it relates to caring for, and fostering community reintegration of persons with disabilities in the face of natural or man made disasters including bioterrorism. RTC/IL at the University of Kansas is developing a model training and evaluation process. The training addresses:

1) The understanding of various aspects of the disability experience

2) Techniques and skills specific to the various disabilities experienced by persons of all ages in all disaster response stages

3) Expand awareness of disability specific and other community resources available to assist in planning and response

4) How to include persons with disabilities of all ages in the tasks of planning, preparation, and execution of preparedness and emergency response

5) Provide model techniques to use to augment existing preparedness and response plans. ▪

“We have become not a melting pot but a beautiful mosaic. Different people, different beliefs, different yearnings, different hopes, different dreams.”

-Jimmy Carter

collaborations

The DHP is the lead agency promoting health and wellness issues for people with a disability. The initial advisory/capacity building efforts have led to strong collaborative relationships with lead disability organizations in the state that have withstood the test of time. These partners continue to serve on the DHSC and, in-turn, DHP staff are actively involved in representing the disability and health perspective in disability advocacy planning and advisory processes. The collaborative table below describes DHP collaborative partners and joint activities. In addition, collaboration with the Statewide Independent Living Council of Kansas, university partners, state and local agencies, and individuals with a disability have expanded the program's knowledge base and expertise, including the capability to provide technical assistance and dissemination of developed products. Kansas Association of Centers for Independent Living (KACIL), Kansas Coalition Against Sexual and Domestic Violence (KCSDV), KDHE and Washburn University's Joint Center on Violence and Victim Studies have played a major role in the program in the last four years.

COLLABORATIVE PARTNER	ACTIVITIES
UNIVERSITY PARTNERS	
- Research and Training Center on Independent Living (RTC/IL at the University of Kansas)	RTC/IL is available for technical assistance, achieving consumer input and evaluation, refinement of the strategic plan and future developments of targeted interventions.
STATE AGENCIES/ORGANIZATIONS	
- Kansas Association for Centers on Independent Living (KACIL)	KACIL provides technical assistance on disability rights and issues through out the state. They agreed to play a key role in disbursing information related to the promotion of health of people with disabilities, access to health care, as well as mentor communities on improved collaboration between crisis services and the Centers for Independent Living.
- Social and Rehabilitation Services (SRS)	Adult Protective Services department of SRS has participated on KCSDV/KDHE/KACIL project. SRS provides trainings on services and the role in a victim's life that is experiencing violence.
- Kansas Coalition Against Sexual and Domestic Violence (KCSDV)	KCSDV, KDHE and KACIL are collaborating partners for the Department of Justice funded disability and violence grant. Partners plan for and arrange all trainings regarding violence against people with disabilities. The partners oversee the completion of products and reports regarding violence against people with disabilities.
- Kansas Department of Administration	The State ADA Coordinator assists the program by distributing disability emergency preparedness materials.
- Brain Injury Association	A collaboration to disseminate information has been established. DHP is a regular contributor to their newsletter.

- Statewide Independent Living Council of Kansas (SILCK)	SILCK takes responsibility for monitoring upcoming legislation and analyzing the effects it can have on people with disabilities. This information has allowed the DHP to build better collaboratatives with service agencies. DHP assists on the planning committee for the Disability Caucus held every two years.
INDIVIDUALS	
- Kansans with disabilities (not professionals in the field)	Individuals with disabilities that are not professionals in the field have participated on Disability Advisory Committee, presented testimonials at trainings and have provided technical assistance on a personal level.
KDHE (INTER-AGENCY COLLABORATION)	
- Breast and Cervical Cancer Prevention	State Comprehensive Cancer Plan includes strategies to address people with a disability. Educational materials are offered in alternative formats.
- Preparedness Program	Hospital training program to accommodate people with disabilities in emergency planning
- Physical Activity/Nutrition Program	KS Kids Fitness Day is structured to include children with disabilities
- Tobacco Prevention Program	-Tobacco Prevention Initiative for Teens includes a focus on disability. The program added questions to the Tobacco Quit Line regarding disability. Educational materials are offered in alternative formats.

- Arthritis Program	-Arthritis Steering Committee regularly contributes to Disability Advisory Committee and DHP are active members of their Steering committee. Educational materials are offered in alternative formats.
- Sexual Violence Prevention Education	-Technical Assistance to programs with a focus on violence against women with disabilities. Educational materials are offered in alternative formats.
- Injury Prevention Program	-Suicide prevention activities with a focus on the disproportionate prevalence of people with disabilities
- Fire/Burn Prevention	-Fire/Burn Prevention program has collaborated and incorporated the needs of people with disabilities in their materials and education. Educational materials are offered in alternative formats.
- Emergency Medical Services for Children	- Technical Assistance to programs includes the focus on children with disabilities. Educational materials are offered in alternative formats.

the priorities

priority areas

The Disability and Health Steering Committee identified three goals to improve the health of people with disabilities. The goals, along with recommended strategies are presented as follows.

Goal 1: All Kansans with disabilities have Access to Health Care.

People with disabilities through out the state have voice concerns on the access to health care. Access issues may be thought of as physical, attitudinal, or financial:

1) Physical access is the ability to access the health care providers place of service. Kansas has many rural areas, especially within the Western half of the state. Many people must travel two to three hours to see medical providers and often time the medical provider is not specialized in disabilities of any kind. In order to address the issue of physical access, Kansas needs to address the availability of medical providers through out the state, as well as means of specialized transport to allow the disabled to visit their clinicians. Health care facilities must also be in compliance with the ADA requirements of physical access, regardless of when the facility was established.
2) Attitudinal access is more complicated to address. It is, in some cases, changing both patient and provider's perception and beliefs of disability. The attitudes can change, and there has been evidence in other states that they did change with education on physical access. Attitudinal access also includes addressing the education needs of the community.

3) Financial access through consideration of the needs of the uninsured and underinsured. Both government and private insurance companies are addressing these needs by offering insurance services at a reduced cost to those that qualify. People who are uninsured or underinsured will seek health care services through more costly emergency services rather than preventative services.

Strategies to Address Access to Health Care:

- Advocate for people with disabilities to work with health care providers in addressing physical access to health care facilities.
- Educate health care providers on the financial assistance and tax credits available to them for removing physical barriers in the office, clinic, or hospital.
- Work with communities to develop and implement care coordination/ case management models proven effective in other communities.
- Expand the use of lay health workers and community volunteers to augment services within health and social service organizations.
- Encourage, develop and support health career pathways for all ages.
- Improve the quality of care by creating incentives and removing barriers for provider coverage to previously uninsured and underinsured clients.
- Educate to remove the attitudinal barriers that are related to disability.

Goal 2: Access to programs aimed at Increasing Physical Activity and Reducing Obesity

Despite the well-established physical and emotional benefits associated with regular participation in moderate physical activity, most Americans are not getting enough activity to reduce their risk of various illnesses. The more than 50 million Americans with disabilities are at much greater risk for developing health problems associated with a sedentary lifestyle.

Kansas's obesity rates, for both adolescents and adults, have steadily increased over the last decade. Obesity contributes to a number of health problems, including diabetes and heart disease. If the current trend continues, by 2020 one out of four health care dollars will pay for obesity-related treatments. Higher percentage of people with disabilities experience obesity (about 1.5 times higher) than people without disabilities (Kansas 2005 BRFSS). People with physical and other disabilities are faced with the lack of access to the opportunity for physical activity.

Strategies to Address Physical Activity and Obesity:

- Health Care Providers can talk with patients about healthy choices and goals. They can encourage patients to adopt a healthy lifestyle to include physical activity, tobacco free living and healthy eating practices.
- Fitness Centers can transition to become accessible to people with disabilities. As equipment needs to be replaced, universal equipment that can be utilized while sitting a wheel chair or used in a variety of ways to increase fitness may be purchased.
- Communities can improve non-automobile travel systems, such as providing sidewalks, curb cuts and wider streets to provide for increased activity and self-transportation.
- Individuals can make small changes to improve choices in nutrition by increasing servings of fruits and vegetables, limiting portion size and controlling total calories. Individuals may also utilize the Internet, library or television to access exercises that can be done while sitting or with limited mobility.

Goal 3: To Reduce Physical and Sexual Violence against People with Disabilities

Information regarding abuse and violence against people with disabilities is alarming. The American Congress of Community Supports and

Employment Services fact sheet reports that crime strikes individuals with disabilities four (4) times more often than the general public, and that sexual assaults and robberies strike individuals with disabilities thirteen (13) times more often (Holding R., 1997). Abuse and Violence in the lives of women with disabilities in Kansas was identified as a health risk factor. Kansas has recently been funded through the Department of Justice for a three year project titled "The Intersection of Violence and Disability". This is a collaborative project involving the Kansas Coalition Against Domestic and Sexual Violence, the Kansas Association Centers on Independent Living and the Kansas Department of Health and Environment.

Strategies to Address Physical and Sexual Violence:

- Raise community awareness of violence and abuse against people with disabilities.
- Educate health providers on signs of abuse and the emphasis of questioning the person alone when ever possible.
- Educate judicial system staff to recognize the potential for abuse
- Educate first responders to better serve people with disabilities
- Coach youth with disabilities in regard to violence prevention and bullying.

Healthy Kansans 2010…encourage change …improve the health of all Kansans.

Throughout 2005, a group of Kansans representing multiple disciplines and organizations came together to identify and adopt health priorities that will improve the health of all Kansans. Healthy Kansans 2010 builds on a comprehensive, nationwide health promotion and disease prevention agenda, Healthy People 2010. Healthy People 2010 is designed to achieve two overarching goals:

(1) Increase quality and years of healthy life. This goal is to help people of all ages increase life expectancy and improve their quality of life.

(2) Eliminate health disparities. This goal is to eliminate health disparities among different segments of the population by specifically targeting the segments that need to improve the most.

HEALTHY KANSANS 2010 HEALTH FOCUS AREAS

- Maternal Infant Child Health
- Oral Health
- Hearing
- HIV & STD
- Family Planning
- Arthritis
- Childhood & Adult Immunization
- Disability
- Environmental Health
- Nutrition and Physical Activity
- Respiratory Health
- Occupational Health
- Vision
- Heart Disease and Stroke
- Diabetes
- Mental Health
- Substance Abuse
- Injury and Violence
- Cancer
- Tobacco
- Chronic Kidney Disease
- Public Health Infrastructure
- Access to Care

These goals are supported by specific objectives in multiple health focus areas. A review of Kansas trends, needs, and strengths in these focus areas provided a foundation for the Healthy Kansans process.

The Healthy Kansans 2010 process resulted in a set of recommendations for change. If implemented, they will markedly improve the health of all Kansans. Progress is measured by the 10 Leading Health Indicators, a snapshot of health in the first decade of the 21st century.

How were the recommendations identified? Participants involved in the Healthy Kansans 2010 identified three cross-cutting issues impacting multiple Leading Health Indicators:

10 LEADING HEALTH INDICATORS

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

- **Reducing and Eliminating Health and Disease Disparities:** This cross-cutting issue builds on one of the two national Healthy People goals. In order to improve the health of all Kansans, it is necessary to reduce and eliminate health and disease disparities among segments of the population that need to improve the most. Health disparities stem from many factors, including race/ethnicity, age, gender, geography (rural/urban), social and economic status, and disability status.
- **System Interventions to Address Social Determinants of Health:** "Social determinants" – issues such as income, education, and social supports – impact the health of Kansans. Recommendations that address social determinants are essential for improving the health of Kansas' population.
- **Early Disease Prevention, Risk Identification and Intervention for Women, Children and Adolescents:** Preventing each potential health problem at the earliest possible point in life is crucial to improving the health of all Kansans.

The next two pages present a few of over 200 specific steps for change that have been identified through the Healthy Kansans 2010 process. The issues listed here are among those that the participants selected for immediate action. We encourage you to visit our website at **http://www.healthykansans2010.org** to view other recommendations and action steps identified by participants that will impact the 10 Leading Health Indicators and improve the health of Kansans. By working together, we can make Kansas a healthier state.

Tobacco: Support a comprehensive tobacco use prevention and control program to reduce exposure to tobacco.

Why is this important?
Twenty percent of adult Kansans smoke (compared to a Healthy People 2010 objective of 16%) contributing to 3,800 deaths annually and $180.4 million in total Medicaid expenditures. One in eight pregnant Kansas women smoke, resulting in poor birth outcomes.

What can I do?
- If you are a smoker, contact the Kansas Tobacco Quitline at 1-866-KAN-STOP
- If you are a health provider, refer patients to the Kansas Tobacco Quitline
- Support tobacco-free policies and ordinances in your community

What can my organization or my community do?
- Adopt tobacco-free policies and ordinances
- Hold meetings and events in tobacco free facilities and on tobacco-free grounds
- Provide smoking cessation opportunities for employees.
- Encourage businesses to fully comply with youth tobacco access laws

What can our state do?
- Increase funding to the Comprehensive Tobacco Program best-practices level ($19.2 – $54.9 million) recommended by the Centers for Disease Control
- Pass a no-compromise, statewide clean indoor air law

Disparities Data: Routinely collect and report data on all segments of the population (race/ethnicity, gender, rural/urban, economic status, disability status) to identify where improvements are most needed.

Why is this important?
Kansas' population is becoming increasingly diverse (e.g., the racial/ethnic minority population has more than doubled since 1980). Without targeted interventions, those with the "worst" health will continue to experience poor and declining health outcomes.

What can I do?
- Participate in valid surveys conducted by state agencies and reputable organizations
- Fill out forms (e.g., hospital admission, birth certificate, Medicare) consistently, completely, and correctly
- Make sure providers are correctly recording your race and ethnicity

What can my organization or my community do?
- Invest in improving your data collection and reporting capacity. Capture all indicators needed to describe the disparate needs of the population you are serving and use standardized data definitions
- Encourage collaboration between data resources
- Participate in state-local partnerships

What can our state do?
- Ensure data collected for all state programs use, at a minimum, federal race/ethnicity collection standards
- Provide data training to communities
- Create a system to monitor multiple health outcomes over the lifespan of Kansans

Cultural Competency: Promote culturally competent health practices among health providers and organizations.

Why is this important?
Culturally competent health providers and organizations are necessary to minimize medical errors and ensure all segments of the population have appropriate health care and prevention services.

What is cultural competency?
An ability to understand and relate to others within the context of culture in a trustworthy manner.

What can I do?
- Clearly communicate your needs and your culture to your health provider
- If you are bilingual, consider becoming trained as a medical interpreter
- If you are a health provider, educator, law enforcement official, etc., attend cultural competency training

What can my organization or my community do?
- Conduct an assessment of your organizations' cultural competency
- Based on your assessment results, implement steps to improve cultural competency

What can our state do?
- Organize, develop, and maintain a statewide cultural competency clearinghouse and resource center
- Promote strategies that improve linguistic accountability and competency, such as expanding and decentralizing health care interpreter programs

Overweight and Obesity: Adopt and implement the five national overweight/obesity prevention goals:
1. Increase fruit and vegetable consumption
2. Increase physical activity
3. Decrease "screen" time (TV, leisure computer, video games)
4. Increase breastfeeding
5. Balance caloric intake with expenditure

Why is this important?
Kansas obesity rates have steadily increased over the last decade for adolescents and adults. Obesity contributes to a number of health problems, including diabetes and heart disease. If the current trend continues, by 2020 one out of four healthcare dollars will pay for obesity related treatments.

What can I do?
- Adopt the national overweight/obesity goals for you and your family, and – if you are a health provider – encourage your patients to adopt this healthy lifestyle.

What can my organization or my community do?
- Adopt policies that support and encourage the national obesity goals among your employees and community members, such as provide breastfeeding-friendly workplaces and hospitals
- Create a "built" community environment that promotes physical activity and non-automobile transportation

What can our state do?
- Develop a comprehensive statewide plan for adopting and implementing the national overweight/obesity goals
- Improve statewide data tracking of overweight/obesity

Access: Assure access to quality health care (including oral health and mental health) and preventive services for all.

What can I do?
- Seek informational resources about health service options in your community and talk with your health provider about when it's appropriate to access care, particularly emergency services

What can my organization or my community do?
- Implement care coordination/case management models proven effective in other communities
- If you are a health or social services organization, expand use of lay health workers or community volunteers to augment services

What can our state do?
- Encourage, develop, and support health career pathways for all ages
- Create incentives and remove barriers to provider coverage to previously uninsured individuals and improve quality of care

Who Is Working on It?

Approximately 40 people representing a broad spectrum of Kansas organizations engaged in the decision-making process where they considered research, sorted information, and defined key cross-cutting or health-themed issues. Another 150 community representatives, experts, and others with a passion for population health participated in one or more of six groups that investigated these issues in depth. Based on all these discussions, crucial action steps were identified, prioritized, and recommended.

To realize these goals, *all* Kansans – individuals, health professionals, communities, businesses, state and local organizations – must partner together in implementing community wide changes for improving the health of Kansans.

What Happens Next?

During 2006, the following activities are taking place:

- Increase awareness of the Healthy Kansans 2010 process and what individuals, organizations, communities, and state leaders can do to improve the health of Kansans
- Encourage action on the recommendations for change
- Implement a process to monitor improvements in the health of Kansans, specifically, improvements in the 10 Leading Health Indicators

Where Can I Find More Information?
How Can I Become More Involved?

Visit our website at **http://www.healthykansans2010.org** or contact:

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